



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

RICHARD L NEEL MD

Respondent Name

EAST TX EDUCATIONAL INSURANCE

MFDR Tracking Number

M4-18-0124-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

September 14, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Amount in Dispute: \$213.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dr. Neel sent a copy of a ledger as proof of timely filing. We have no record of receiving this bill prior to 8/3/17. It is our position denial should be maintained as provider has not provided satisfactory documentation for timely filing."

Response Submitted by: Claims Administrative Services, Inc.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
November 18, 2016	99214 and 99080-73	\$213.00	\$164.13

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. 28 Texas Administrative Code §133.20 sets out the medical bill submission procedures for health care providers.
4. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
5. Texas Labor Code §408.027 sets out the rules for timely submission of claims by health care providers.
6. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical bill.
7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 29 – Time limit for filing has expired
 - 719 – Per rule 133.20 a medical bill shall not be submitted later than the 95th day after the date of service

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. What are the reimbursement rules for CPT Code 99214?
3. Did the requestor forfeit the right to reimbursement for CPT Code 99080-73?

Findings

1. The requestor seeks reimbursement for CPT Codes 99080-73 and 99214 rendered on November 18, 2016. 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."
The requestor submitted a copy of a ledger in support of timely filing. Review of this documentation supports timely filing for CPT Code 99214, which was identified in this documentation. The same documentation did not identify CPT Code 99080-73 as part of the billed charges for this date of service. As a result, the division finds that the submitted documentation supports that the requestor submitted CPT Code 99214 to the insurance carrier within the required timeframes and finds that the insurance carrier's denial for this service is not supported. The Division will review this service according to the applicable rules and guidelines. However, the requestor submitted insufficient documentation to support that CPT Code 99080-73 was submitted within the 95-day timeframe. As a result, reimbursement cannot be recommended for CPT Code 99080-73.
2. Review of the submitted documentation supports that the requestor billed for CPT Code 99214 on November 18, 2016. The requestor submitted an evaluation and management document to support the billing of this service. As a result, the requestor is entitled to reimbursement for the disputed service.

28 Texas Administrative Code §134.203 (c) (1) states "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32. 2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

Procedure code 99214, rendered on November 18, 2016, is a professional service paid per Rule §134.203(c). For this code, the relative value (RVU) for work of 1.5 multiplied by the geographic practice cost index (GPCI) for work of 1 is 1.5. The practice expense (PE) RVU of 1.42 multiplied by the PE GPCI of 0.92 is 1.3064. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.822 is 0.0822. The sum of 2.8886 is multiplied by the division conversion factor of \$56.82 for a MAR of \$164.13. Therefore this amount is recommended.

3. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."
28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."
Review of the submitted information for CPT Code 99080-73 finds insufficient documentation to support that a medical bill was submitted within 95 days from the date the service was provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor has forfeited the right to reimbursement for CPT Code 99080-73 due to untimely submission of the medical bill for the disputed service.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$164.13.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$164.13 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	October 5, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** along with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812